The Connecticut State Innovation Model

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Vision

Establish a whole-person-centered healthcare system that improves population health and eliminates health inequities; ensures superior access, quality, and care experience; empowers individuals to actively participate in their healthcare; and improves affordability by reducing healthcare costs

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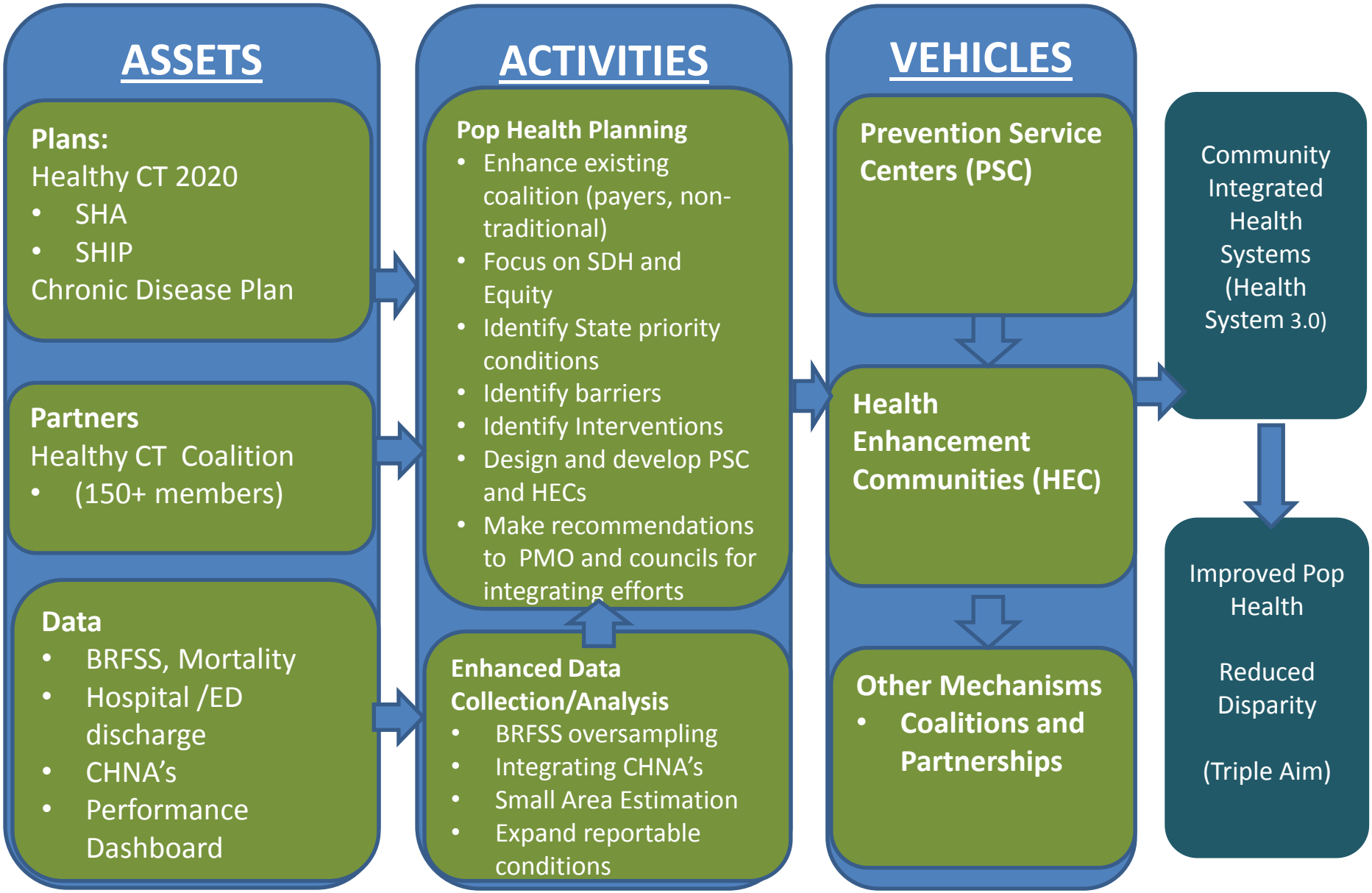
Today's Agenda

Statewide Initiatives	
Commissioner Mullen	Population health plan
Mark Schaefer	Payment reform: Alignment with Medicare SSP
Tom Woodruff	Value-based Insurance Design
Commissioner Bremby	Health Information Technology
Targeted Initiatives	
Kate McEvoy	Medicaid Quality Improvement & Shared Savings Program
Mark Schaefer	Primary Care Transformation
	• Advanced Medical Home Glide Path • Community and Clinical Integration Program
	Governance Why Connecticut?

Statewide Initiatives

Improved Population Health

Population Health Improvement Pathway



Improved Population Health

	Baseline	Healthy CT 2020 Target
Diabetes: undiagnosed Type II		
Connecticut overall	93,000	88,350
Smoking Rates		
Students in grades 6-8	2.9%	2.2%
Students in grades 9 - 12	14.0	10.5%
Obesity Rates		
Adults 18 years of age and older	25.6%	24.3%

Payment Reform

Value-Based Payment

- SIM design process spurred a multi-payer commitment to value-based payment
- Accelerated the organization of providers to accept accountability for quality and total cost of care
- Under our model test grant, payers further committed to alignment with the Medicare Shared Savings Program (SSP)

Value-Based Payment

- Today, 13 major provider organizations are participating in the Medicare SSP as ACOs, what we refer to as *Advanced Networks*
- Three additional Advanced Networks will participate by January 2015
- Connecticut State Medical Society established an ACO option for independent physicians
- The ACO structure is becoming the *default standard* in Connecticut

Value-Based Payment

- Federally Qualified Health Centers are seeking opportunities to assume accountability for quality and total cost of care
- Medicaid's participation, combined with SIM funded technical assistance, will enable FQHCs to develop these capabilities
- And it will enable Advanced Networks to achieve a predominance of SSP arrangements

Opportunities for Alignment with Medicare SSP

- Conditions of participation
- Governance
- Leadership and management structure
- Program integrity & compliance plan
- Marketing, beneficiary information & notification
- Quality Measures
- Shared savings methodology

Quality Measure Alignment

- Improve efficiency, reduce complexity
- Improve focus, support quality improvement
- Make care experience matter
- Measure and reward health equity gains

Quality Council

- Maximize alignment with the Medicare Shared Savings Program ACO measure set
- Add measures to address:
  - Gaps, e.g., pediatrics, reproductive health
  - Areas of emphasis such as behavioral health, health equity, and care experience.
- Wherever possible, draw from established measures
- Accelerate migration to outcome-based measures
- Commitment to transparency

Shared Savings Program

Participation Projections

Year	Beneficiaries	%
2016	1,305,000	38%
2017	1,745,000	50%
2018	2,270,000	64%
2019	2,596,000	73%
2020	3,117,000	88%

Value-Based Insurance Design

Value-Based Insurance Design

- Value-based payment most effective when paired with an insurance design that rewards positive health behavior
  - Self-management of chronic conditions
  - Participation in preventative services
  - Healthy lifestyle

Value-Based Insurance Design
Goals

Develop prototype VBID plan designs that align supply and demand while enabling streamlined administration

Provide a mechanism for employers to share best practices to accelerate the adoption of VBID plans

Value-Based Insurance Design
Key Partners

- Connecticut Business and Industry Association
- Connecticut Business Group on Health
- Northeast Business Group on Health
- Office of the State Comptroller (state employee health plan)

Value-Based Insurance Design
Plan Components

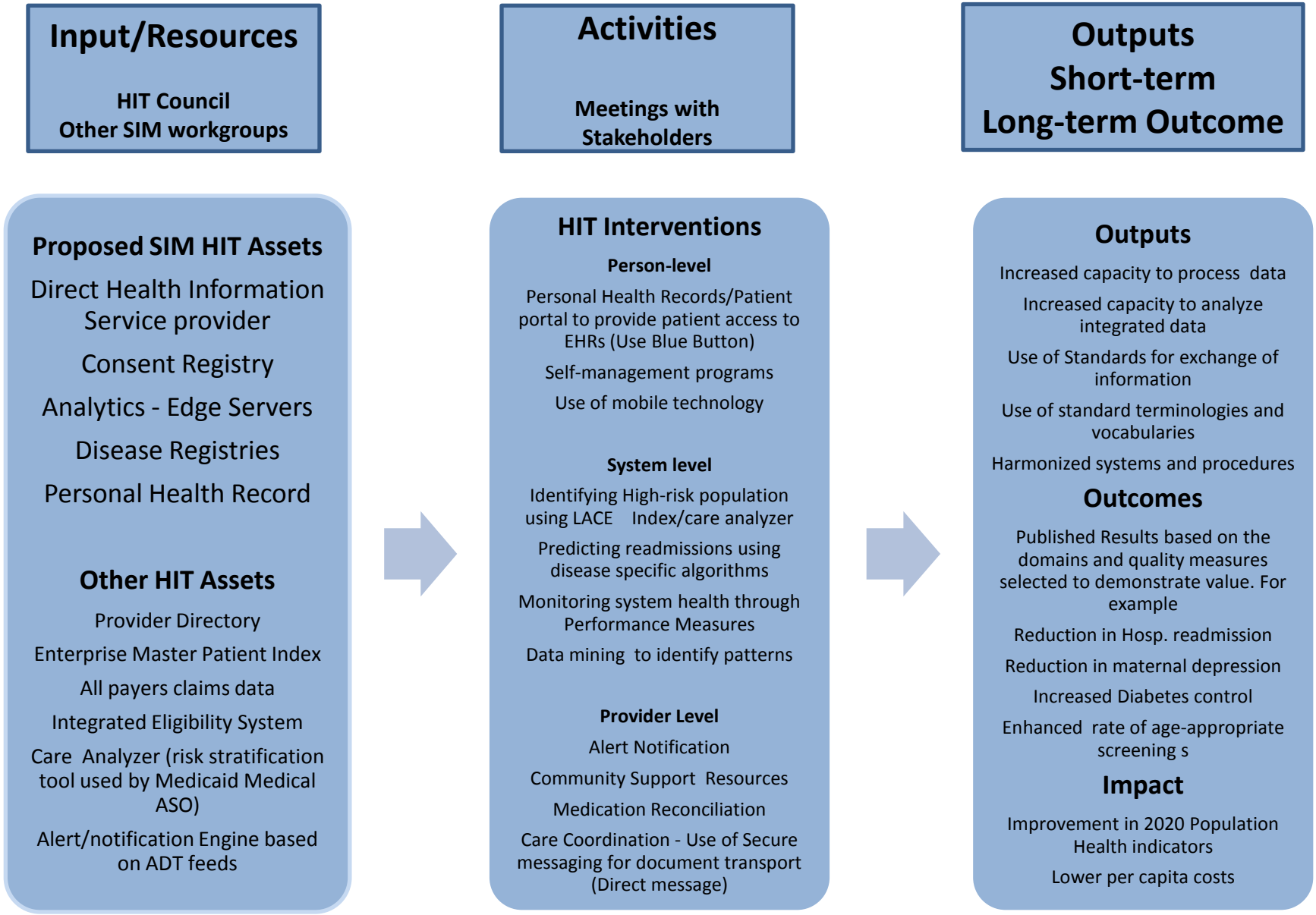
- Establish employer-led consortium with core interest sub-groups (e.g. clinical, wellness, administration) and linkages to regional and national forums such as CMMI's VBID learning cluster to enable peer-to-peer sharing of best practices
- Develop VBID template(s) and implementation toolkits;
- Convene an annual learning collaborative, including panel discussions with nationally recognized experts and technical assistance; and
- Facilitate a workforce health outcomes pilot.
- Subject to board approval, Access Health CT will implement VBID in Year 2 of the Model Test.

Value-Based Insurance Design
Accountability Metrics

Year	Percent adoption
2016	44%*
2017	53%
2018	65%
2019	74%
2020	85%

*Estimate – will establish empirical baseline 2015

Health Information Technology


Input/Resources
HIT Council
Other SIM workgroups
Activities
Meetings with Stakeholders
Outputs
Short-term
Long-term Outcome
Proposed SIM HIT Assets
Direct Health Information Service provider
Consent Registry
Analytics - Edge Servers
Disease Registries
Personal Health Record
Other HIT Assets
Provider Directory
Enterprise Master Patient Index
All payers claims data
Integrated Eligibility System
Care Analyzer (risk stratification tool used by Medicaid Medical ASO)
Alert/notification Engine based on ADT feeds
HIT Interventions
Person-level
Personal Health Records/Patient portal to provide patient access to EHRs (Use Blue Button)
Self-management programs
Use of mobile technology
System level
Identifying High-risk population using LACE Index/care analyzer
Predicting readmissions using disease specific algorithms
Monitoring system health through Performance Measures
Data mining to identify patterns
Provider Level
Alert Notification
Community Support Resources
Medication Reconciliation
Care Coordination - Use of Secure messaging for document transport (Direct message)
Outputs
Increased capacity to process data
Increased capacity to analyze integrated data
Use of Standards for exchange of information
Use of standard terminologies and vocabularies
Harmonized systems and procedures
Outcomes
Published Results based on the domains and quality measures selected to demonstrate value. For example
Reduction in Hosp. readmission
Reduction in maternal depression
Increased Diabetes control
Enhanced rate of age-appropriate screening s
Impact
Improvement in 2020 Population Health indicators
Lower per capita costs

Health Information Technology

Direct Messaging

- Allow secure exchange of clinical documents, such as discharge summaries, orders, and continuity of care documents.
- Generate health alerts and reminders to improve care, especially for patients with chronic conditions.
- As of January 2015, most certified EHRs will be enabled with Direct Messaging.
- Model Test funds will be used to provide Direct Messaging addresses to providers that are not eligible for the CMS EHR incentive program, including behavioral health, long-term care, and home-health agencies

Health Information Technology

Consent Registry

- Managing patient consent is a burden on providers and interferes with efficient and timely communication
- Consent registry can be queried to assess consumer consent status with respect to sharing of information
- State bond funds have already supported core procurement of the registry
- SIM funds will be used to further enhance the Consent Registry

Health Information Technology
Analytics/Edge Server

- DSS will create provider, organization, and state-level data reports enabled by edge-server based indexing technology that allows both large and small providers to access data and analytics equally, irrespective of resource constraints.
- These reports will provide actionable data to improve healthcare delivery interventions.
- Existing state bond funding and CMS funding will jointly support the license for this technology and development costs, which will be supplemented by Model Test funding in Years 3 and 4.

Health Information Technology

Disease Registry

- Disease Registries will be procured based on the population's identified needs through crowd sourcing

Health Information Technology

Personal Health Record

- Patient access to personal health record empowers them to be informed decision makers with their providers
- DSS is working with CMS to initiate a project to provide PHRs to all Medicaid beneficiaries.
- Same PHR will be made available to commercial and Medicare beneficiaries who do not otherwise have access to a PHR

Targeted Initiatives

Medicaid Quality Improvement and Shared Savings Program (MQISSP)

Medicaid QISSP

Procurement

- DSS will procure FQHCs and Advanced Networks to participate in Medicaid QISSP
- Selection based on:
  - demonstrated commitment, experience and capacity to serve Medicaid beneficiaries;
  - ability to meet identified standards for clinical and community integration;
  - willingness to invest in special capabilities such as data analytics, quality measurement and rapid cycle improvement;
  - 5,000 attributed single-eligible Medicaid beneficiaries.

Medicaid QISSP
Procurement

- Priority given to:
  - Participation in Medicare and commercial SSP arrangements to maximize multi-payer alignment,
  - Situated in areas of critical need in the state for the Medicaid population, as evidenced by disease burden, disparities and cost of care.

Medicaid QISSP
Planning & Oversight

- SIM related Medicaid planning integrated with longstanding Medicaid advisory structure
- Medical Assistance Program Oversight Council (MAPOC)
  - Care Management/PCMH committee will advise re: the development of Medicaid QISSP
  - SIM consumer advocates will participate
  - MAPOC representatives will be participate with SIM workgroups

Medicaid QISSP
Protections

- Upside only SSP
- Implement only when reasonable and necessary methods for monitoring under-service are in place
- New patient advocate position in the Office of the Healthcare Advocate

Medicaid QISSP
Implementation

- Two waves during the grant period
  - January 2016
  - January 2018
- Third wave projected 2020
- Estimate 200 to 215,000 beneficiaries in the first wave

Medicaid QISSP

Participation Projections

Year	Beneficiaries	%
2016	205,000	30%
2017	210,000	30%
2018	429,000	60%
2019	439,000	61%
2020	636,000	89%

Primary Care Transformation

Advanced Medical Home Glide Path
Building the Foundation

- Practice transformation support
- Modeled after existing Medicaid Person Centered Medical Home (PCMH) Glide Path program
- Accountability for meeting milestones
- Targeted to practices affiliated with Advanced Networks
  - Offered more widely within available resources
- On-site validation

Advanced Medical Home Glide Path

- NCQA standards & recognition
  - Establish additional “must pass” elements or factors or consider “new” elements if they align with our vision, e.g., health equity analysis & quality improvement
  - Consider alignment with CPCI capabilities
- Learning Collaborative
  - open to PCPs, staff, and practice administrators to facilitate peer-to-peer learning and interdisciplinary networking for primary care transformation

AMH Glide Path – Accountability Metrics

Year		Primary Care Practices	
		Target	Percentage
2015	**Population N**	**500**	
	1st Quarter	0	0%
	2nd Quarter	0	0%
	3rd Quarter	50	10%
	4th Quarter	100	20%
2016	**Population N**	**500**	
	1st Quarter	150	30%
	2nd Quarter	250	50%
	3rd Quarter	250	50%
	4th Quarter	250	50%
2017	**Population N**	**500**	
	1st Quarter	250	50%
	2nd Quarter	250	50%
	3rd Quarter	325	65%
	4th Quarter	400	80%
2018	**Population N**	**500**	
	1st Quarter	500	100%
	2nd Quarter	500	100%
	3rd Quarter	500	100%
	4th Quarter	500	100%

Community and Clinical Integration
Enabling the Enterprise

- Targeted Technical Assistance
  - Focus on identified priority areas, opportunities for significant quality and/or cost improvement; major emphasis on building bridges to the community to address social determinants
- Innovation Awards
  - Competitive grant process will foster innovations that align with our vision and strategy. PMO will establish an Innovation Awards advisory committee to establish award criteria and processes.
- Learning collaboratives
  - Two dedicated collaboratives, one tailored to FQHCs and the other to Advanced Networks

Community and Clinical Integration

For participating Advanced Networks and FQHCs

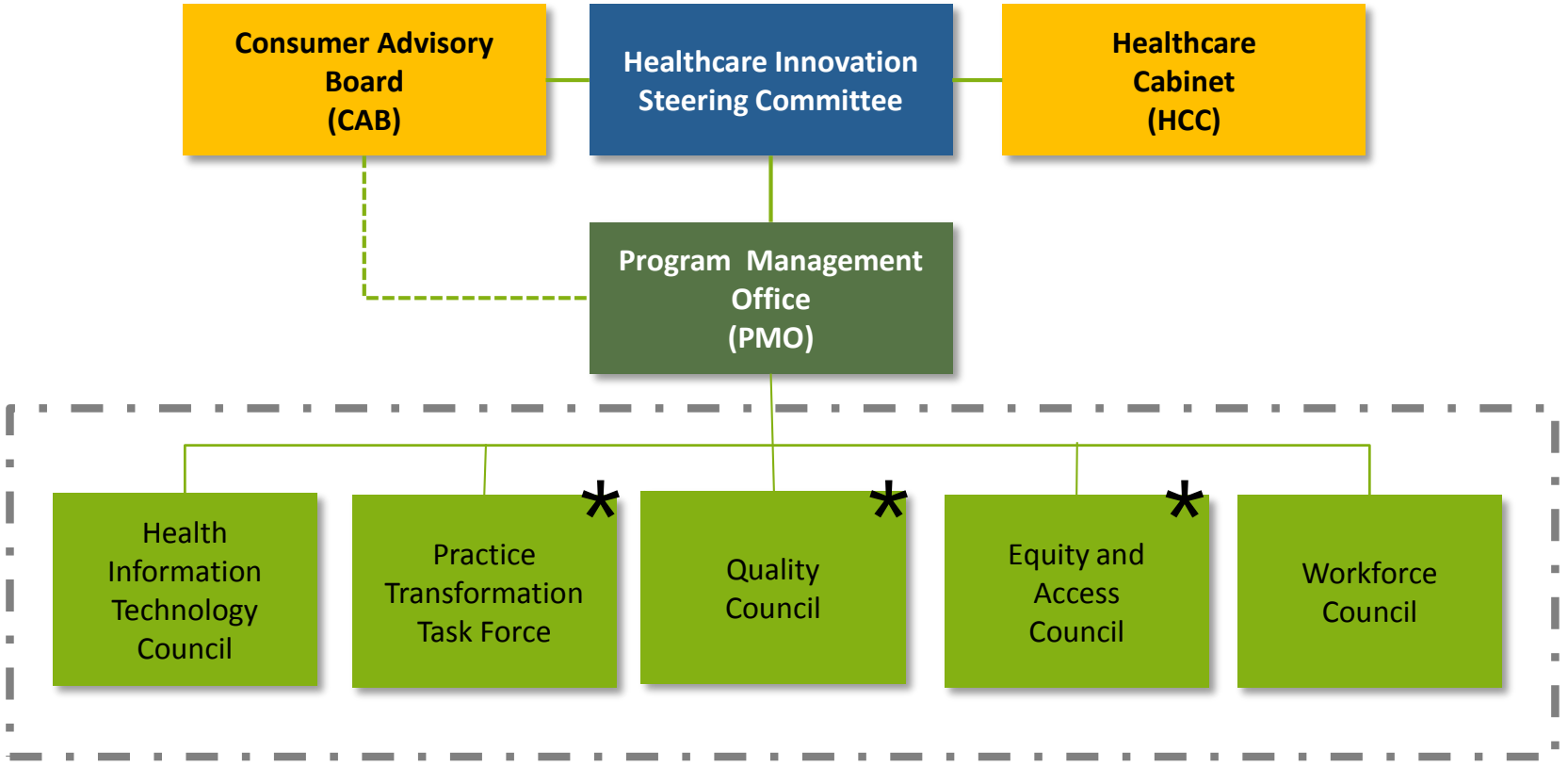
1) integrating behavioral health and oral health,
2) providing medication therapy management services,
3) building dynamic clinical teams,
4) expanding e-consults between PCPs and specialists,
5) incorporating community health workers,
6) closing health equity gaps,
7) improving the care experience for vulnerable populations,
8) establishing community linkages
9) identifying “super utilizers” for community care teams

Community and Clinical Integration

Additional assistance areas for FQHCs

1) enhancing primary care provider/staff skills in quality improvement methods and analytics; and
2) producing actionable quality improvement reports.

SIM Governance Structure



SIM Governance Structure

- Balanced and proportionate representation
  - Consumer advocates, providers, state agencies, payers
- More than 40 consumer advocates
- Substantial physician participation including:
  - President, CT State Medical Society,
  - Governor, CT Chapter of the American College of Physicians,
  - President, CT Academy of Family Physicians
  - Former President, CT Chapter of the Academy of Pediatrics
- Integration with the Medical Assistance Program Oversight Council

Why Connecticut?

- Unprecedented collaboration across diverse partners
- Strong record of success & commitment to sustain
- Intent to lead the nation:
  - Empowering consumers
  - Making care experience matter
  - Putting health equity into the value equation
  - Integrating behavioral health
  - Consumer safeguards
- Demonstrated commitment among all of Connecticut's commercial payers
- Ensure success of Medicare ACO model

Questions